LIST OF EXHIBITS

A. 3-Responses from Terri Pechner-James with jurat.

B. 3-Responses from Sonia Fernandez with jurat.

C.1 Medical Authorizations of Terri Pechner-James & Certificate of Service

C.2 Medical Authorizations of Sonia Fernandez & Certificate of Service

D. Plaintiffs February 17, 2006 Letter to Reardon, Joyce & Akerson, P.C.

E. Response from MGH HealthCare Center dated Feb, 13, 2006.

F. Electronic Certificate of Service Missing From The Akerson document.

G. February 6, 2006 Letter to Reardon, Joyce & Akerson, P.C. about Dr. Barry.

EXHIBIT A

EXHIBIT B

CERTIFICATE OF SERVICE

I, hereby certify that I served the following documents electronically to the City of Revere, Thomas Ambrosino, Mayor, Revere Police Department, Terrence Reardon, Chief, by emailing said documents and sending said documents to the parties listed below by regular mail, postage prepaid:

Plaintiffs Request For Reconsideration of Order On Motion For Sanctions:Docket #115 and Exhibits A through G.

Walter H. Porr, Esq.
Paul Capizzi, Esq.
Office of the City Solicitor
281 Broadway
Revere, MA 02151

John K. Vigliotti, Esq.
Michael J. Akerson, Esq.
Reardon, Joyce & Akerson, P.C.
397 Grove Street
Worcester, MA 01650

/s/ James S. Dilday, Esq. James S. Dilday
James S. Dilday, Esq.
27 School Street, Suite 400
Boston, MA 02108
(617) 227-3470

Date: February 22, 2006

EXHIBIT C-1

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION, MEDICAL, HOSPITAL, MENTAL HEALTH AND OTHER RECORDS

I, TERRI PECHNER JAMES,

hereby authorize: DEBORAH WALD, M.D.

to disclose and release to my attorneys, Grayer & Dilday, 27 School Street (Suite 400), Boston MA 02108, all protected health information, medical, hospital, psychiatric, and psychological records without limitation regarding my medical, mental health condition, drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or tests for or infection with human immunodeficiency virus (HIV) as revealed by your observation or treatment, past, present and future.

This includes history, findings, x-rays, notes, diagnosis, prognosis, pre-existing conditions, complications, aggravations, doctor's orders, laboratory reports, intake evaluation, and discharge summaries, operative and physical therapy reports, counseling records and any and all writings comprising the full and complete documentation of my medical or mental health treatment at your facility for examination and photocopying.

This authorization extends to any party who has medical information concerning my physical or mental health condition past, present or future and therefore specifically

includes any doctor, nurse, psychiatrist, psychologist, counselor, social worker or therapist who has examined, interviewed, or treated me, and any facility or hospital where I have been examined, interviewed or treated.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I have carefully read and understand the above statements, and do herein expressly and voluntarily authorize disclosure of the information hereby requested, to my attorneys Grayer & Dilday. I understand that this authorization is subject to revocation at any time by requesting such of the above-referenced hospital or party in writing unless action based on it has already begun. I understand that this authorization is will expire 90 days from date of said authorization. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

Steve Lamb

Signature of patient or patient's representative

Date

1 Patriot Lane Georgetown Ma 01833

Patient's Address City State Zip

1978-3525565

Patient's telephone #

04-29-73

Date of Birth

Relationship to patient or authority to act for patient

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION, MEDICAL, HOSPITAL, MENTAL HEALTH AND OTHER RECORDS

I, TERRI PECHNER JAMES

hereby authorize: DR. ELIZABETH MILLER

to disclose and release to my attorneys, Grayer & Dilday, 27 School Street (Suite 400), Boston MA 02108, all protected health information, medical, hospital, psychiatric, and psychological records without limitation regarding my medical, mental health condition, drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or tests for or infection with human immunodeficiency virus (HIV) as revealed by your observation or treatment, past, present and future.

This includes history, findings, x-rays, notes, diagnosis, prognosis, pre-existing conditions, complications, aggravations, doctor's orders, laboratory reports, intake evaluation, and discharge summaries, operative and physical therapy reports, counseling records and any and all writings comprising the full and complete documentation of my medical or mental health treatment at your facility for examination and photocopying.

This authorization extends to any party who has medical information concerning my physical or mental health condition past, present or future and therefore specifically

includes any doctor, nurse, psychiatrist, psychologist, counselor, social worker or therapist who has examined, interviewed, or treated me, and any facility or hospital where I have been examined, interviewed or treated.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I have carefully read and understand the above statements, and do herein expressly and voluntarily authorize disclosure of the information hereby requested, to my attorneys Grayer & Dilday. I understand that this authorization is subject to revocation at any time by requesting such of the above-referenced hospital or party in writing unless action based on it has already begun. I understand that this authorization is will expire 90 days from date of said authorization. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

Signature of patient or patient's representative — Date: 1/26/2006

1 Patriot Lane — Georgetown — MA — 01833
Patient's Address — City — State — Zip

978-352-5965 — Patient's telephone #

4/29/1973 — Date of Birth

Relationship to patient or authority to act for patient

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION, MEDICAL, HOSPITAL, MENTAL HEALTH AND OTHER RECORDS

I, TERRI PECHNER JAMES,

hereby authorize: DR. SUSAN RUDMAN

to disclose and release to my attorneys, **Grayer & Dilday, 27 School Street (Suite 400), Boston MA 02108,** all protected health information, medical, hospital, psychiatric, and psychological records without limitation regarding my medical, mental health condition, drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or tests for or infection with human immunodeficiency virus (HIV) as revealed by your observation or treatment, past, present and future.

This includes history, findings, x-rays, notes, diagnosis, prognosis, pre-existing conditions, complications, aggravations, doctor's orders, laboratory reports, intake evaluation, and discharge summaries, operative and physical therapy reports, counseling records and any and all writings comprising the full and complete documentation of my medical or mental health treatment at your facility for examination and photocopying.

This authorization extends to any party who has medical information concerning my physical or mental health condition past, present or future and therefore specifically

includes any doctor, nurse, psychiatrist, psychologist, counselor, social worker or therapist who has examined, interviewed, or treated me, and any facility or hospital where I have been examined, interviewed or treated.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I have carefully read and understand the above statements, and do herein expressly and voluntarily authorize disclosure of the information hereby requested, to my attorneys Grayer & Dilday. I understand that this authorization is subject to revocation at any time by requesting such of the above-referenced hospital or party in writing unless action based on it has already begun. I understand that this authorization is will expire 90 days from date of said authorization. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

Signature of patient or patient's representative — Date: 1/26/2006

Patient's Address: 1 Patriot Case — City: Georgetown — State: MA — Zip: 01833

Patient's telephone #: 1-978-352-5965 — Date of Birth: 4-29-73 — Relationship to patient or authority to act for patient:

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION, MEDICAL, HOSPITAL, MENTAL HEALTH AND OTHER RECORDS

I, TERRI PECHNER JAMES,

hereby authorize: DR. BARRY

to disclose and release to my attorneys, Grayer & Dilday, 27 School Street (Suite 400), Boston MA 02108, all protected health information, medical, hospital, psychiatric, and psychological records without limitation regarding my medical, mental health condition, drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or tests for or infection with human immunodeficiency virus (HIV) as revealed by your observation or treatment, past, present and future.

This includes history, findings, x-rays, notes, diagnosis, prognosis, pre-existing conditions, complications, aggravations, doctor's orders, laboratory reports, intake evaluation, and discharge summaries, operative and physical therapy reports, counseling records and any and all writings comprising the full and complete documentation of my medical or mental health treatment at your facility for examination and photocopying.

This authorization extends to any party who has medical information concerning my physical or mental health condition past, present or future and therefore specifically

includes any doctor, nurse, psychiatrist, psychologist, counselor, social worker or therapist who has examined, interviewed, or treated me, and any facility or hospital where I have been examined, interviewed or treated.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I have carefully read and understand the above statements, and do herein expressly and voluntarily authorize disclosure of the information hereby requested, to my attorneys Grayer & Dilday. I understand that this authorization is subject to revocation at any time by requesting such of the above-referenced hospital or party in writing unless action based on it has already begun. I understand that this authorization is will expire 90 days from date of said authorization. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

Teresa Paine — 1/26/2006
Signature of patient or patient's representative — Date

1 Parnot Lane — Georgetown — MA — 01833
Patient's Address — City — State — Zip

978-352-5765 — 4/29/1973 — _____
Patient's telephone # — Date of Birth — Relationship to patient or authority to act for patient

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION, MEDICAL, HOSPITAL, MENTAL HEALTH AND OTHER RECORDS

I, ~~TERRI PECHNER JAMES~~,

hereby authorize: ERIC J. KEROACK, MD

_____

_____,

to disclose and release to my attorneys, **Grayer & Dilday, 27 School Street (Suite 400), Boston MA 02108,** all protected health information, medical, hospital, psychiatric, and psychological records without limitation regarding my medical, mental health condition, drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or tests for or infection with human immunodeficiency virus (HIV) as revealed by your observation or treatment, past, present and future.

This includes history, findings, x-rays, notes, diagnosis, prognosis, pre-existing conditions, complications, aggravations, doctor's orders, laboratory reports, intake evaluation, and discharge summaries, operative and physical therapy reports, counseling records and any and all writings comprising the full and complete documentation of my medical or mental health treatment at your facility for examination and photocopying.

This authorization extends to any party who has medical information concerning my physical or mental health condition past, present or future and therefore specifically

includes any doctor, nurse, psychiatrist, psychologist, counselor, social worker or therapist who has examined, interviewed, or treated me, and any facility or hospital where I have been examined, interviewed or treated.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I have carefully read and understand the above statements, and do herein expressly and voluntarily authorize disclosure of the information hereby requested, to my attorneys Grayer & Dilday. I understand that this authorization is subject to revocation at any time by requesting such of the above-referenced hospital or party in writing unless action based on it has already begun. I understand that this authorization is will expire 90 days from date of said authorization. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

Signature of patient or patient's representative — Date: 1/26/2006

1 Patriot Lane — Georgetown — MA — 01833

Patient's Address — City — State — Zip

1978-352-5963 — Patient's telephone #

4-22-1973 — Date of Birth

Relationship to patient or authority to act for patient

CERTIFICATE OF SERVICE

I, James Dilday, hereby certify that I served upon the parties listed below the enclosed Authorization To Release Protected Health Information, Medical, Hospital, Mental Health And Other Records for Terri Pechner-James by mailing to them at the addresses listed herein:

1. Eric Keroack, M.D.
   103 Broadway St.
   Revere, MA 02151

2. Susan Rudman
   70 Washington Street, suite 211
   Salem, MA 01970

3. Dr. Barry
   268 Main Street
   Stoneham, MA

4. Dr. Elizabeth Miller
   Dr. Deborah Wald
   Massachusetts General Hospital
   300 Ocean Avenue
   Revere, MA 02151

James S. Dilday, Esq.

Date: January 26, 2006

EXHIBIT C-2

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION, MEDICAL, HOSPITAL, MENTAL HEALTH AND OTHER RECORDS

I, SONIA FERNANDEZ,

hereby authorize: MGH REVERE HEALTH CENTER

to disclose and release to my attorneys, Grayer & Dilday, 27 School Street (Suite 400), Boston MA 02108, all protected health information, medical, hospital, psychiatric, and psychological records without limitation regarding my medical, mental health condition, drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or tests for or infection with human immunodeficiency virus (HIV) as revealed by your observation or treatment, past, present and future.

This includes history, findings, x-rays, notes, diagnosis, prognosis, pre-existing conditions, complications, aggravations, doctor's orders, laboratory reports, intake evaluation, and discharge summaries, operative and physical therapy reports, counseling records and any and all writings comprising the full and complete documentation of my medical or mental health treatment at your facility for examination and photocopying.

This authorization extends to any party who has medical information concerning my physical or mental health condition past, present or future and therefore specifically

includes any doctor, nurse, psychiatrist, psychologist, counselor, social worker or therapist who has examined, interviewed, or treated me, and any facility or hospital where I have been examined, interviewed or treated.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I have carefully read and understand the above statements, and do herein expressly and voluntarily authorize disclosure of the information hereby requested, to my attorneys Grayer & Dilday. I understand that this authorization is subject to revocation at any time by requesting such of the above-referenced hospital or party in writing unless action based on it has already begun. I understand that this authorization is will expire 90 days from date of said authorization. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

Sonia Fernandes
Signature of patient or patient's representative

11/24/06
Date

Patient's Address City State Zip

Patient's telephone # Date of Birth Relationship to patient or authority to act for patient

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION, MEDICAL, HOSPITAL, MENTAL HEALTH AND OTHER RECORDS

I, SONIA FERNANDEZ,

hereby authorize: NORTH SUFFOLK COUNSELING SERVICES

to disclose and release to my attorneys, Grayer & Dilday, 27 School Street (Suite 400), Boston MA 02108, all protected health information, medical, hospital, psychiatric, and psychological records without limitation regarding my medical, mental health condition, drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or tests for or infection with human immunodeficiency virus (HIV) as revealed by your observation or treatment, past, present and future.

This includes history, findings, x-rays, notes, diagnosis, prognosis, pre-existing conditions, complications, aggravations, doctor's orders, laboratory reports, intake evaluation, and discharge summaries, operative and physical therapy reports, counseling records and any and all writings comprising the full and complete documentation of my medical or mental health treatment at your facility for examination and photocopying.

This authorization extends to any party who has medical information concerning my physical or mental health condition past, present or future and therefore specifically

includes any doctor, nurse, psychiatrist, psychologist, counselor, social worker or therapist who has examined, interviewed, or treated me, and any facility or hospital where I have been examined, interviewed or treated.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I have carefully read and understand the above statements, and do herein expressly and voluntarily authorize disclosure of the information hereby requested, to my attorneys Grayer & Dilday. I understand that this authorization is subject to revocation at any time by requesting such of the above-referenced hospital or party in writing unless action based on it has already begun. I understand that this authorization is will expire 90 days from date of said authorization. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

Sonia Fernandes — 11/26/06

Signature of patient or patient's representative — Date

Patient's Address — City — State — Zip

Patient's telephone # — Date of Birth — Relationship to patient or authority to act for patient

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION, MEDICAL, HOSPITAL, MENTAL HEALTH AND OTHER RECORDS

I, **SONIA FERNANDEZ**,

hereby authorize: **BETH ISRAEL DEACONESS EAST BOSTON NEIGHBORHOOD HEALTH CENTER**

to disclose and release to my attorneys, **Grayer & Dilday, 27 School Street (Suite 400), Boston MA 02108,** all protected health information, medical, hospital, psychiatric, and psychological records without limitation regarding my medical, mental health condition, drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or tests for or infection with human immunodeficiency virus (HIV) as revealed by your observation or treatment, past, present and future.

This includes history, findings, x-rays, notes, diagnosis, prognosis, pre-existing conditions, complications, aggravations, doctor's orders, laboratory reports, intake evaluation, and discharge summaries, operative and physical therapy reports, counseling records and any and all writings comprising the full and complete documentation of my medical or mental health treatment at your facility for examination and photocopying.

This authorization extends to any party who has medical information concerning my physical or mental health condition past, present or future and therefore specifically

includes any doctor, nurse, psychiatrist, psychologist, counselor, social worker or therapist who has examined, interviewed, or treated me, and any facility or hospital where I have been examined, interviewed or treated.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I have carefully read and understand the above statements, and do herein expressly and voluntarily authorize disclosure of the information hereby requested, to my attorneys Grayer & Dilday. I understand that this authorization is subject to revocation at any time by requesting such of the above-referenced hospital or party in writing unless action based on it has already begun. I understand that this authorization is will expire 90 days from date of said authorization. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

Sonia Fernandez
Signature of patient or patient's representative

11/26/06
Date

Patient's Address City State Zip

Patient's telephone # Date of Birth Relationship to patient or authority to act for patient

CERTIFICATE OF SERVICE

I, James Dilday, hereby certify that I served upon the parties listed below the enclosed Authorization To Release Protected Health Information, Medical, Hospital, Mental Health And Other Records for Sonia Fernandez by mailing to them at the addresses listed herein:

1. MGH Chelsea Health Center
151 Everett Av. Chelsea,
MA 02150

Beth Israel Deaconess Health Care
East Boston Neighborhood Health Center
1000 Broadway,
Chelsea, 02150

Massachusetts General Hospital Revere health Center
300 Broadway
Revere, MA 02151

North Suffolk Counseling Services
301 Broadway,
Chelsea, MA 02150

Occupational Health Rehabilitation Center
1 Harborside Drive,
E. Boston, MA 02128

Meditrol, Inc.
145 Springfield Street
Chicopee, MA 01013

James S. Dilday

James S. Dilday, Esq.

Date: January 26, 2006

CERTIFICATE OF SERVICE

I, James Dilday, hereby certify that I served upon the parties listed below the enclosed Authorization To Release Protected Health Information, Medical, Hospital, Mental Health And Other Records for Sonia Fernandez by mailing to them at the addresses listed herein:

1. MGH Chelsea Health Center
151 Everett Av. Chelsea,
MA 02150

Beth Israel Deaconess Health Care
East Boston Neighborhood Health Center
1000 Broadway,
Chelsea, 02150

Massachusetts General Hospital Revere health Center
300 Broadway
Revere, MA 02151

North Suffolk Counseling Services
301 Broadway,
Chelsea, MA 02150

Occupational Health Rehabilitation Center
1 Harborside Drive,
E. Boston, MA 02128

Meditrol, Inc.
145 Springfield Street
Chicopee, MA 01013

James S. Dilday

James S. Dilday, Esq.

Date: January 26, 2006

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION, MEDICAL, HOSPITAL, MENTAL HEALTH AND OTHER RECORDS

I, SONIA FERNANDEZ,

hereby authorize: MGH_CHELSEA HEALTH CENTER

_____

_____,

to disclose and release to my attorneys, **Grayer & Dilday, 27 School Street (Suite 400), Boston MA 02108,** all protected health information, medical, hospital, psychiatric, and psychological records without limitation regarding my medical, mental health condition, drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or tests for or infection with human immunodeficiency virus (HIV) as revealed by your observation or treatment, past, present and future.

This includes history, findings, x-rays, notes, diagnosis, prognosis, pre-existing conditions, complications, aggravations, doctor's orders, laboratory reports, intake evaluation, and discharge summaries, operative and physical therapy reports, counseling records and any and all writings comprising the full and complete documentation of my medical or mental health treatment at your facility for examination and photocopying.

This authorization extends to any party who has medical information concerning my physical or mental health condition past, present or future and therefore specifically

includes any doctor, nurse, psychiatrist, psychologist, counselor, social worker or therapist who has examined, interviewed, or treated me, and any facility or hospital where I have been examined, interviewed or treated.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I have carefully read and understand the above statements, and do herein expressly and voluntarily authorize disclosure of the information hereby requested, to my attorneys Grayer & Dilday. I understand that this authorization is subject to revocation at any time by requesting such of the above-referenced hospital or party in writing unless action based on it has already begun. I understand that this authorization is will expire 90 days from date of said authorization. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

Sonia Fernandez
Signature of patient or patient's representative

11/24/06
Date

Patient's Address City State Zip

Patient's telephone # Date of Birth Relationship to patient or authority to act for patient

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION, MEDICAL, HOSPITAL, MENTAL HEALTH AND OTHER RECORDS

I, SONIA FERNANDEZ,

hereby authorize: OCCUPATIONAL HEALTH & REHABILITATION CENTER

to disclose and release to my attorneys, Grayer & Dilday, 27 School Street (Suite 400), Boston MA 02108, all protected health information, medical, hospital, psychiatric, and psychological records without limitation regarding my medical, mental health condition, drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or tests for or infection with human immunodeficiency virus (HIV) as revealed by your observation or treatment, past, present and future.

This includes history, findings, x-rays, notes, diagnosis, prognosis, pre-existing conditions, complications, aggravations, doctor's orders, laboratory reports, intake evaluation, and discharge summaries, operative and physical therapy reports, counseling records and any and all writings comprising the full and complete documentation of my medical or mental health treatment at your facility for examination and photocopying.

This authorization extends to any party who has medical information concerning my physical or mental health condition past, present or future and therefore specifically

includes any doctor, nurse, psychiatrist, psychologist, counselor, social worker or therapist who has examined, interviewed, or treated me, and any facility or hospital where I have been examined, interviewed or treated.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I have carefully read and understand the above statements, and do herein expressly and voluntarily authorize disclosure of the information hereby requested, to my attorneys Grayer & Dilday. I understand that this authorization is subject to revocation at any time by requesting such of the above-referenced hospital or party in writing unless action based on it has already begun. I understand that this authorization is will expire 90 days from date of said authorization. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

Sonia Fernandez — 11/26/06

Signature of patient or patient's representative — Date

Patient's Address — City — State — Zip

Patient's telephone # — Date of Birth — Relationship to patient or authority to act for patient

EXHIBIT D

Grayer & Dilday, LLP

COUNSELLORS-AT-LAW
27 SCHOOL STREET – SUITE 400
BOSTON, MASSACHUSETTS 02108
TEL. (617) 227-3470 • FAX (617) 227-9231

February 17, 2006

John K. Vigilotti, Esq.
Reardon, Joyce & Akerson, P.C.
397 Grove Street
Worcester, MA 01605

Re; Pechner-James and Fernandez-Medical Releases

Dear Attorney Vigliotti,

On January 26, 2006, we sent you the following documents on Terri Pechner-James:

1. Release of Medical Records sent to the following parties:

Eric J. Keroack, M.D.
103 Broadway
Revere, MA 02151

Dr. Susan Rudman
70 Washington Street, Suite 211
Salem, MA 01970

Dr. Barry
268 Main Street
Stoneham, MA

Dr. Elizabeth Miller
Dr. Deborah Wald
Massachusetts General Hospital
300 Ocean Avenue
Revere, MA 02151

We also provided you with the attached Certificate of Service. We have provided you with the records from Dr. Rudman. Our letter to Dr. Barry has been returned and after a diligent search we have been unable to locate him. On February 6, 2006, we sent you a letter requesting your help with locating Dr. Barry because he provided services to the police officers of the City of Revere. We have not received a response from you.

We have not, to date, received additional records from the other parties named in the certificate of service.

On January 26, 2006, we sent you the following documents on Sonia Feranadez.

Release of Medical Records sent to the following:

MGH Chelsea Health Center
151 Everett Avenue
Chelsea, MA 02150

Beth Israel Deaconess Health Care
East Boston Neighborhood Health Care
1000 Broadway
Chelsea, MA 02150

Massachusetts General Hospital
Revere Health Center
300 Broadway
Revere, MA 02151

North Suffolk Counseling Service
301 Broadway
Chelsea, MA 02150

Occupational Health Rehabilitation Center
1 Harborside Drive
East Boston, MA 02128

Meditrol , Inc.
145 Springfield Street
Chicopee, MA 01013

We have not yet received additional records from these providers.

We would like to make the following suggestion. If you prepare releases on your letter-head, forward them to us, we would have our clients sign them and we will return them to you so that you can send them directly to the providers named herein. Please give us a call if you have any questions.

Sincerely,

James S. Dilday

James S. Dilday, Esq.

CERTIFICATE OF SERVICE

I, James Dilday, hereby certify that I served upon the parties listed below the enclosed Authorization To Release Protected Health Information, Medical, Hospital, Mental Health And Other Records for Sonia Fernandez by mailing to them at the addresses listed herein:

1. MGH Chelsea Health Center
151 Everett Av. Chelsea,
MA 02150

Beth Israel Deaconess Health Care
East Boston Neighborhood Health Center
1000 Broadway,
Chelsea, 02150

Massachusetts General Hospital Revere health Center
300 Broadway
Revere, MA 02151

North Suffolk Counseling Services
301 Broadway,
Chelsea, MA 02150

Occupational Health Rehabilitation Center
1 Harborside Drive,
E. Boston, MA 02128

Meditrol, Inc.
145 Springfield Street
Chicopee, MA 01013

James S. Dilday

James S. Dilday, Esq.

Date: January 26, 2006

CERTIFICATE OF SERVICE

I, James Dilday, hereby certify that I served upon the parties listed below the enclosed Authorization To Release Protected Health Information, Medical, Hospital, Mental Health And Other Records for Terri Pechner-James by mailing to them at the addresses listed herein:

1. Eric Keroack, M.D.
   103 Broadway St.
   Revere, MA 02151

2. Susan Rudman
   70 Washington Street, suite 211
   Salem, MA 01970

3. Dr. Barry
   268 Main Street
   Stoneham, MA

4. Dr. Elizabeth Miller
   Dr. Deborah Wald
   Massachusetts General Hospital
   300 Ocean Avenue
   Revere, MA 02151

James S. Dilday

James S. Dilday, Esq.

Date: January 26, 2006

Grayer & Dilday, LLP

COUNSELLORS-AT-LAW
27 SCHOOL STREET – SUITE 400
BOSTON, MASSACHUSETTS 02108
TEL. (617) 227-3470 • FAX (617) 227-9231

February 6, 2006

Michael Akerson, Esq.
John Vigliotti, Esq.
Reardon, Joyce & Akerson, P.C.
397 Grove Street
Worcester, MA 01605

Re: Sonia Fernandez' records held by Dr. Barry

Dear Attys Akerson and Vigliotti,

The request for documents that we sent to Dr. Barry has been returned to this office because the postal service was unable to deliver it. The purpose of this letter is to ask you to provide us with the correct address of Dr. Barry so that we can send the request to that address. Dr. Barry was a medical contractor for the City of Revere. The Plaintiffs have had no contact with him since the end of their employment with the City of Revere.

We look forward to hearing from you.

Sincerely,

James S. Dilday.

James S. Dilday, Esq.

EXHIBIT E

MGH CHELSEA HEALTHCARE CENTER
HEALTH INFORMATION
151 EVERETT AVE.
CHELSEA, MA 02150

Attn: JAMES S. DILDAY,ESQ
GRAYER & DILDAY, LLP
COUNSELLORS AT LAW
27 SCHOOL ST. SUITE 400
BOSTON, MA 02108

February 13, 2006

TEL: 617-227-3470

RE: 1815062 FERNANDEZ, SONIA

Your request concerning the above mentioned patient has been received and is being returned for the reason (s) indicated below:

( ) We have no record of this patient having been treated at the hospital.

( ) Patient was not seen on the date (s) indicated on your request.

( ) We cannot release medical information without first receiving a signed original authorization from the patient or, if the patient is deceased or a minor, from the authorized representative or from the next of kin.

( ) Additional information is needed to identify this patient, i.e., date of birth, spelling of name or possible other name of treating M.D. or clinic, approximate date of visit/treatment.

( ) Please return your signed request along with the address of the physician, attorney,or other agency to whom you wish your records sent.

( ) copying fee of $125.60 is required.
COPIES WILL BE SENT UPON RECEIPT OF PAYMENT.
( ) other:

Thank you for your cooperation.

Sincerely

Sharon Cecca,
Correspondence Section,

MGH Chelsea
HealthCare Center
151 Everett Avenue, Chelsea, MA 02150

UNITED STATES POSTAGE
PITNEY BOWES
02 1A $ 00.39⁰
0004394377 FEB 14 2006
MAILED FROM ZIP CODE 02114

Attn: JAMES S. DILDAY,ESQ
GRAYER & DILDAY, LLP
COUNSELLORS AT LAW
27 SCHOOL ST. SUITE 400
BOSTON, MA 02108

CONFIDENTIAL

02108+4633-99 C013

EXHIBIT F

2. Unless exempt or otherwise ordered by the court, all pleadings and other papers must be served on other parties by electronic means. Any pleading or other paper served by electronic means must bear a certificate of service in accordance with Local Rule 5.2(b) stating that the document has been filed electronically and that it will be served electronically to registered ECF participants and by sending paper copies to non-registered participants as indicated on the NEF.

Example:

Certificate of Service

I hereby certify that this document(s) filed through the ECF system will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF) and paper copies will be sent to those indicated as non registered participants on _(date)_.

3. Transmission of the NEF through the court's transmission facilities will constitute service of the filed document upon a registered ECF user and shall be deemed to satisfy the requirements of Fed.R.Civ.P.5(b)(2)(D), Fed.R.Civ.P.77(d) and Fed.R.Crim.P.49(b). The attorney filing the document electronically is responsible for serving a paper copy of the document by mail in accordance with Fed.R.Civ.P.5(b) to those case participants who have not been identified on the NEF as electronic recipients.

4. Service by electronic means shall be treated the same as service by mail for the purpose of adding three (3) days to the prescribed period to respond. In accordance with Local Rule 7.1, a party opposing a motion, shall file an opposition to the motion within fourteen (14) days after service of the motion, unless another period is fixed by rule or statute, or by order of the court. The fourteen day period is intended to include the period specified by the civil rules for mailing time and provide for a uniform period regardless of the use of the mails.

F. Subsequent Documents with Fee Requirement

Subsequent documents filed in a case which require a fee, such as a notice of appeal, motion for leave to appear pro hac vice, etc. must be electronically filed . However, until the court implements a credit card payment option through ECF, the required fee must be paid within 24 hours after the document is submitted electronically. A copy of the Notice of Electronic Filing should be submitted with the fee to the clerk's office so that it can be properly reconciled with the case.

EXHIBT G

Grayer & Dilday, LLP

COUNSELLORS-AT-LAW
27 SCHOOL STREET – SUITE 400
BOSTON, MASSACHUSETTS 02108
TEL. (617) 227-3470 • FAX (617) 227-9231

February 6, 2006

Michael Akerson, Esq.
John Vigliotti, Esq.
Reardon, Joyce & Akerson, P.C.
397 Grove Street
Worcester, MA 01605

Re: Sonia Fernandez' records held by Dr. Barry

Dear Attys Akerson and Vigliotti,

The request for documents that we sent to Dr. Barry has been returned to this office because the postal service was unable to deliver it. The purpose of this letter is to ask you to provide us with the correct address of Dr. Barry so that we can send the request to that address. Dr. Barry was a medical contractor for the City of Revere. The Plaintiffs have had no contact with him since the end of their employment with the City of Revere.

We look forward to hearing from you.

Sincerely,

James S. Dilday.

James S. Dilday, Esq.